1 2	EDMUND G. BROWN JR., Attorney General of the State of California  ARTHUR D. TAGGART:  Supervising Deputy Attorney General  GEOFFREY S. ALLEN, State BARNOR 93338  Deputy Attorney General 327 313 38  1300 I Street, Suite 125	
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4	P.O. Box 944255	
5	Sacramento, CA 94244-2550 Telephone: (916) 324-5341	
6	Facsimile: (916) 327-8643	
7	Attorneys for Complainant	
8	BEFORE THE BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA	
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11		L Com No 2000 LL C
12	In the Matter of the Accusation Against:	Case No. 2009 - 162
13	MARTILEE MEHAN MIGASI, AKA MARTILEE MEHAN	ACUSATION
14	15 Dahlia Way Chico, CA 95926	
15	Registered Nurse License No. 431761	
. 16	Respondent.	
17		
18	Complainant alleges:	
19	<u>PARTIES</u>	
20	1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation	
21	solely in her official capacity as the Executive Officer of the Board of Registered Nursing	
22	("Board"), Department of Consumer Affairs.	
23	2. On or about August 31, 1988, the Board of Registered Nursing issued	
24	Registered Nurse License Number 431761 to Martilee Mehan Migasi, also known as Martilee	
25	Mehan ("Respondent"). The license will expire on October 31, 2009, unless renewed.	
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#### STATUTORY PROVISIONS

- Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive licensee, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.
- 4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.
  - 5. Code section 2761 states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- (a) Unprofessional conduct. . . .
- (f) Conviction of a felony or of any offense substantially related to the qualifications, functions and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.
  - 6. Code section 2762 states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

- (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
- (c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions(a) and (b) of this section, or the possession of, or the falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.
- (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

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7. Code section 4022 provides, in pertinent part,

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

- (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.
  - 8. Code section 4060 provides, in pertinent part,

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

9. Health and Safety Code section 11173, subdivision (a), provides:

No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

## **COST\_RECOVERY**

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

#### **DRUGS**

- 11. "Hydomorphone" or "Dilaudid", a brand name of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(k), and is a dangerous drug within the meaning of Code section 4022, in that under federal law it requires a prescription.
- 12. "Pethidine"/ "Merperidine Hydrochloride" or "Demerol", a brand name of pethidine or merperidine hydrochloride, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17), and is a dangerous drug within the meaning of Code section 4022, in that under federal law it requires a prescription.

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Patient 1

On or about February 8, 2007, at 0711, 1044, 1351, and 1735 hours, Respondent signed out 4 mg. of Morphine each time from the Omnicell medication dispenser for this patient, and failed to chart the administration or wastage of the Morphine in any patient or hospital record or otherwise account for the disposition of the drug.

Patient 2

On or about February 8, 2007, at 1513 hours, Respondent signed out 3 tabs b. of Norco from the Omnicell medication dispenser for this patient and charted the administration

# Oroville Hospital

Between, but not limited to, July 2008 and September 2008, while working as a registered nurse at Oroville Hospitakin Oroville, California, Respondent did the following:

Respondent obtained Demerol, Morphine, and Dilaudid, controlled substances, by fraud, deceit, misrepresentation or subterfuge, or the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a), by taking the drugs from Oroville Hospital's supplies for her own personal use.

- Respondent possessed Demerol, Morphine, and Dilaudid, controlled substances, in violation of Code section 4060.
- Respondent self-administered Demerol, Morphine, and Dilaudid, f. controlled substances, without direction from a licensed physician, surgeon, dentist or podiatrist

# SECOND CAUSE FOR DISCIPLINE

(False, Grossly Inconsistent or Unintelligible Entries in Hospital or Patient Records)

16. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), as follows:

On or about February 8, 2007, while working as a registered nurse at MGH, Respondent falsified or made grossly incorrect entries in hospital or patient records, including, but not limited to, the following:

of 2 tabs at 1500 hours. Respondent failed to chart the administration of the remaining 1 tab of Norco in any patient or hospital record or otherwise account for the disposition of the drug.

# Patient 3 40 aga of 8 1037 course of 1837 course

c. On or about February 8, 2007, at 0759, 1429, and at 1735 hours, Respondent removed two 4 mg./1 ml. syringes of Morphine each time, and at 1045 and 1222 hours, Respondent signed out one 4 mg./1ml. syringes of Morphine each time from the Omnicell medication dispenser for this patient. Respondent charted the administration of 6 mg. of Morphine at 1420 hours. Respondent charted the administration of Morphine at "1215" but failed to chart the dosage. Respondent failed to chart the administration of the remaining 26 mg. of Morphine in any patient or hospital record or otherwise account for the disposition of the drug.

## Oroville Hospital

Between September 9, 2008 and September 21, 2008, while working as a registered nurse at Oroville Hospital in Oroville, California, Respondent falsified or made grossly incorrect entries in hospital or patient records, including, but not limited to, the following:

#### Patient A

- d. On or about September 19, 2008, Respondent charted the administration of 25 mg. of Demerol each time at 1710, 1020, 1730, and 1740 hours to this patient. The physician's order was for 12.5 mg. prn up to a maximum dose of 100 mg. Respondent failed to administer the dosage as prescribed.
- e. On or about September 19, 2008, at 1745 hours, Respondent signed out 10 mg. of Morphine for this patient, but failed to chart the administration or wastage of the Morphine in any patient or hospital record or otherwise account for the disposition of the drug.

#### Patient B

f. On or about September 19, 2008, at 1900 hours, Respondent signed out 50 mg. of Demerol, and at 1915 hours, Respondent signed out 25 mg. of Demerol for this patient. The physician's order was for 25 mg. q 5 minutes up to a maximum dose of 75 mg. Respondent charted the administration of 25 mg. at 1905 hours, 12.5 mg. at 1910 hours, 25 mg. at 1915

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hours, and 25 mg. at 1920 hours, to this patient, failing to administer the drug as prescribed. Respondent charted the administration of 87.5 mg of Demerol to this patient; however, she documented the withdrawal of only 75 mg of Demerol for this patient.

g. On or about September 19,2008, at 1930 hours, Respondent signed out 4 mg. of Morphine for this patient, but failed to chart the administration or wastage of the Morphine in any patient or hospital record or otherwise account for the disposition of the drug.

### Patient C

h. On or about September 21, 2008, Respondent charted the administration of 12.5 mg. of Demerol each time at 0045 hours and 0050 hours, and 25 mg. of Demerol each time at 0105, 0110, 0115, and 0120 hours to this patient. The physician's order was for 12.5 mg. prn up to a maximum dose of 100 mg. Respondent failed to administer the drug a prescribed.

#### Patient D

- i. On or about September 18, 2008, at 1630 hours, Respondent signed out 50 mg. of Demerol for this patient. The physician's order was for 12.5 mg. prn up to a maximum dose of 100 mg. Respondent charted the administration of 25 mg. of Demerol each time at 1610, 1615, 1620, and 1625 hours (prior to its recorded withdrawal), to this patient, failing to administer the drug as prescribed. Respondent charted the administration of 100 mg. of Demerol for this patient; however, she documented the withdrawal of only 50 mg. of Demerol for this patient.
- j. On or about September 18, 2008, at 1640 hours, Respondent signed out 4 mg. of Morphine for this patient, but failed to chart the administration or wastage of the Morphine in any patient or hospital record or otherwise account for the disposition of the drug.
- k. On or about September 18, 2008, at 1650 hours, Respondent signed out 10 mg. of Morphine for this patient, but failed to chart the administration or wastage of the Morphine in any patient or hospital record or otherwise account for the disposition of the drug.

## Patient E

1. On or about September 16, 2008, at 1330, 1340, and 1350 hours,

Respondent signed out 2 mg. of Dilaudid each time. Respondent charted the administration of 1

mg. of Dilaudid each time at 1325, 1330, 1335, and 1340 hours, to this patient. Respondent failed to chart the administration of wastage of the remaining 2 mg. of Dilaudid in any patient or hospital record or otherwise account for the disposition of the drug.

m. On or about September 16, 2008, at 1400 hours, Respondent signed out 4 mg. of Morphine for this patient, but failed to chart the administration or wastage of the Morphine in any patient or hospital record or otherwise account for the disposition of the drug

#### Patient F

- n. On or about September 9, 2008, Respondent charted the administration of 25 mg. of Demerol each time at 1605 and 1610 hours to this patient. The physician's order was for 12.5 mg. prn. Respondent failed to administer the drug as prescribed.
- o. On or about September 9, 2008, at 1645 hours, Respondent signed out 2 mg. of Dilaudid for this patient, without a physician's order. Respondent failed to chart the administration or wastage of the Dilaudid in any patient or hospital record or otherwise account for the disposition of the drug

#### THIRD CAUSE FOR DISCIPLINE

(Prescribe and Administer Controlled Substance)

under Code section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in Code section 2762, subdivision (a), in that between September 9, 2008, and September 21, 2008, while working as a licensed registered nurse at Oroville Hospital in Oroville, California, Respondent's administration of dangerous drugs to patients exceeded the physicians' directions for administration of those drugs, as set forth in paragraph 16, subparagraphs d, f, h, i, and n, above.

#### FORTH CAUSE FOR DISCIPLINE

(Conviction)

18. Respondent's registered nurse license is subject to discipline under Code section 2761, subdivision (f), and Code section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in Code section 2762, subdivision (c), in that on or about,

1	January 5, 2009, in the Superior Court of California, County of Sacramento, in the case entitled,		
2	People of the State of California v. Martilee Migasi (Super. Ct. Sacramento County, 2008, Case		
3	No. 08F05672), Respondent was convicted on her plea of guilty of violating Health and Safety		
4	Code section 11173, subd. (a), (obtaining a controlled substance by fraud, deceit,		
5	misrepresentation or subterfuge), a felony. The circumstances of the crimes are detailed above in		
6	paragraphs 15 and 16. This crime is substantially related to the functions, qualifications, and		
7	duties of a registered nurse.		
8	PRAYER		
9	WHEREFORE, Complainant requests that a hearing be held on the matters		
10	herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:		
11	1. Revoking or suspending Registered Nurse License Number 431761, issued		
12	to Martilee Mehan Migasi, also known as Martilee Mehan;		
13	2. Ordering Martilee Mehan Migasi, also known as Martilee Mehan, to pay		
14	the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this		
15	case, pursuant to Code section 125.3; and,		
16	3. Taking such other and further action as deemed necessary and proper.		
17	DATED: 1/26/09		
18	Rita On Ti		
19	RUTH ANN TERRY, M.P.H., R.N. Executive Officer Board of Registered Nursing Department of Consumer Affairs		
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21	State of California Complainant		
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